prevent organ allograft rejection (West et al. 1987; Venkataseshan et al. 1990; Ahn et al. 1992; Delaney et al. 1992; George and Mandell 1995).

Hyperuricemia can result from both urate overproduction and underexcretion (Hershfield and Seegmiller 1976; Kelley et al. 1989; Becker and Roessler 1995). When

5   mild, hyperuricemia can be controlled with diet, but when pronounced and associated with serious clinical consequences, it requires treatment with drugs, either a uricosuric agent that promotes uric acid excretion (ineffective if renal function is reduced), or the xanthine oxidase inhibitor allopurinol, which blocks urate formation. Allopurinol is the mainstay of therapy in patients with tophaceous gout, renal insufficiency, leukemia, and

10 some inherited disorders. Treatment for hyperuricemia is generally effective and well-tolerated. However, some patients with disfiguring, incapacitating tophaceous gout are refractory to all conventional therapy (Becker 1988; Fam 1990; Rosenthal and Ryan 1995). Moreover, ~2% of patients treated with allopurinol develop allergic reactions, and a severe hypersensitivity syndrome occurs in ~0.4% (Singer and Wallace 1986;

15 Arellano and Sacristan 1993). This often life-threatening syndrome can cause acute renal and hepatic failure, and severe skin injury (toxic epidermal necrolysis, exfoliative dermatitis, erythema multiforme, Stevens-Johnson syndrome). Allopurinol also interferes with the metabolism of azathioprine and 6-mercaptopurine, drugs used in the treatment of leukemia and for prevention of organ allograft rejection, conditions in

20 which marked hyperuricemia occurs and may cause severe gout or threaten renal function.

Ultimately, hyperuricemia is the result of mutational inactivation of the human gene for urate oxidase (uricase) during evoultion (Wu et al. 1989; Wu et al. 1992). Active uricase in liver peroxisomes of most non-human primates and other mammals

25 converts urate to allantoin (+ CO_2 and H_2O_2), which is 80-100 times more soluble than uric acid and is handled more efficiently by the kidney. Parenteral uricase, prepared from *Aspergillus flavus* (Uricozyme®, Clin-Midy, Paris), has been used to treat severe hyperuricemia associated with leukemia chemotherapy for over 20 years in France and Italy (London and Hudson 1957; Kissel et al. 1968; Brogard et al. 1972; Kissel et al.

30 1972; Potaux et al. 1975; Zittoun et al. 1976; Brogard et al. 1978; Masera et al. 1982), and has been used in recent clinical trials in leukemia patients in the US (Pui et al.

1997). Uricase has a more rapid onset of action than allopurinol (Masera et al. 1982; Pui et al. 1997). In patients with gout, uricase infusions can interrupt acute attacks and decrease the size of tophi (Kissel et al. 1968; Potaux et al. 1975; Brogard et al. 1978).

5   Though effective for treating acute hyperuricemia during a short course of chemotherapy, daily infusion of *A. flavus* uricase would be a serious drawback for treating recurrent or tophaceous gout. In addition, efficacy of *A. flavus* uricase diminishes quickly in patients who develop anti-uricase antibodies (Kissel et al. 1968; Brogard et al. 1978; Escudier et al. 1984; Mourad et al. 1984; Sibony et al. 1984). Serious allergic reactions, including anaphylaxis, have occurred (Donadio et al. 1981;

10   Montagnac and Schillinger 1990; Pui et al. 1997). A longer-acting, less immunogenic preparation of uricase is clearly needed for chronic therapy.

       One approach for sequestering exogenous enzymes from proteases and the immune system involves covalent attachment of the inert, nontoxic polymer, monomethoxypolyethylene glycol (PEG) to the surface of proteins (Harris and Zalipsky

15   1997). Use of PEGs with Mr ~1,000 to >10,000 was first shown to prolong the circulating life and reduce the immunogenicity of several foreign proteins in animals (Abuchowski et al. 1977a; Abuchowski et al. 1977b; Davis et al. 1981a; Abuchowski et al. 1984; Davis et al. 1991). In 1990, bovine adenosine deaminase (ADA) modified with PEG of Mr 5000 (PEG-ADA, ADAGEN®, produced by Enzon, Inc.) became the first

20   PEGylated protein to be approved by the United States Food and Drug Administration, for treatment of severe combined immune deficiency disease due to ADA deficiency (Hershfield et al. 1987). Experience over the past 12 years has shown that anti-ADA antibodies can be detected by a sensitive ELISA in most patients during chronic treatment with PEG-ADA, but there have been no allergic or hypersensitivity reactions;

25   accelerated clearance of PEG-ADA has occurred in a few anti-ADA antibody producing patients, but this has usually been a transient effect (Chaffee et al. 1992; Hershfield 1997). It should be appreciated that immune function of patients with ADA deficiency usually does not become normal during treatment with PEG-ADA (Hershfield 1995; Hershfield and Mitchell 1995). Thus, immunogenicity might be a more significant

30   problem in developing a PEGylated enzyme for chronic treatment of patients with normal immune function.

Immunogenicity will be understood by one of ordinary skill as relating to the induction of an immune response by an injected preparation of an antigen (such as PEG-modified protein or unmodified protein), while antigenicity refers to the reaction of an antigen with preexisting antibodies. Collectively, antigenicity and immunogenicity are

5   referred to as immunoreactivity. In previous studies of PEG-uricase, immunoreactivity was assessed by a variety of methods, including: the reaction *in vitro* of PEG-uricase with preformed antibodies; measurements of induced antibody synthesis; and accelerated clearance rates after repeated injections.

PEGylation has been shown to reduce the immunogenicity and prolong the

10   circulating life of fungal and porcine uricases in animals (Chen et al. 1981; Savoca et al. 1984; Tsuji et al. 1985; Veronese et al. 1997). PEG-modified *Candida* uricase rapidly lowered serum urate to undetectable levels in 5 normouricemic human volunteers (Davis et al. 1981b) . PEGylated *Arthrobacter* uricase produced by Enzon, Inc. was used on a compassionate basis to treat an allopurinol-hypersensitive patient with lymphoma,

15   who presented with renal failure and marked hyperuricemia (Chua et al. 1988; Greenberg and Hershfield 1989). Four intramuscular injections were administered over about two weeks. During this brief period, hyperuricemia was controlled and no anti-uricase antibody could be detected by ELISA in the patient's plasma. Further use and clinical development of this preparation has not been pursued.

20   To date, no form of uricase or PEG-uricase has been developed that has a suitably long circulating life and sufficiently reduced immunogenicity for safe and reliable use in chronic therapy. The aim of this invention is to provide an improved form of uricase that, in combination with PEGylation, can meet these requirements. The invention is a unique recombinant uricase of mammalian derivation, which has been

25   modified by mutation in a manner that has been shown to enhance the ability of PEGylation to mask potentially immunogenic eptiopes.

Summary of the Invention

30   It is a general object of the present invention to provide novel uricase proteins and nucleic acid sequences encoding same.